Effective Date	SD2 Prod ID	Title	Technical Description
8/22/2011	320	Phase II Void/Replacment Claims Referencing Phase I Claims	Phase II Void and Replacement claims referencing Phase I Claim IDs as the Original Reference Number (REF02) will be Denied with a CO 129 Error.
8/22/2011	331	Therapeutic Behavioral Services TBS (H2019) Excluded from Other Health Coverage (OHC) Edit	Allow claims for Therapeutic Behavioral Services (H2019) to be directly billed to Medi-Cal (both Medi-Medi and Other Health Coverage COB exclusions). *(Note: Targeted Case Management Services (T1017) are currently Directly Billable service claims to Medi-Cal regardless of Medi-Medi or Other Health Coverage status.)*
8/22/2011	345	DMH Statewide Maximum Rates (SMA) Rates FY 11/12	a. DMH Statewide Maximum Allowance (SMA) Rates for Fiscal Year 11/12 were implemented per DMH Information Notice 11-08. b. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) State General Fund (SGF) Reimbursement Rate for Fiscal Year 11/12 changed to 0% per AB 100.
5/20/2011	162	DRC 3 Expires 9/30/2011	Allow the use of DRC 3 through 9/30/11 for original claims. Denied DRC 3 claims may be replaced through the 97-day period after 9/30/11.
5/2/2011	317	Coordination of Benefits (COB) Balancing Error	System Fix for Claims Inappropriately Denied with the Error Code CO A1, N480 [Incomplete/Invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)].
4/5/2011	93	Do not reject 837P transaction set for COB balancing errors	System will not reject transaction sets for Coordination of Benefits (COB) balancing errors. Unbalanced COB information in a transaction set shall not cause any unit of EDI (transaction set, functional group, or interchange envelope/file) to be rejected. Claims with unbalanced COB will be denied with CO A1, N480 [Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)].
4/5/2011	265	Replacement Claim Timeliness Rules (Delete exception)	Allow replacement claims with a delay reason code to be adjudicated for original claims that were denied for being late and could not be replaced when the replacement claim was submitted more than 12 months after the month of service.
4/5/2011	296	Edifecs Code Lists Update (termination of G8437)	HIPAA Code Set Update (EDIFECS EDI Standards - HIPAA External Code Lists v7.0.8 /v6.6.32 Release Notes)
2/25/2011	270	CR 85 Clean Up, Previous Adjudicated Claims	835s will be generated for previously adjudicated $0 approved claims prior to 1/10/2011.
2/25/2011	277	Medication Training and Support H0034 Code for Medi-Medi Claims	Any claim that has procedure code H0034, Medication Training and Support, will not require submission to Medicare before being submitted to SDMC for payment. (H0034 replaces G8437 which was terminated 12/31/10.)
2/25/2011	278	Allow HQ and SC with additional procedure codes.	Allow modifiers HQ (Community) and SC (Telephone) to be used with or without the following procedure codes: T1017, H0032, H2017, H2019, G8437, H2011, H0034
2/25/2011	288	System Fix for Modifier Comparison in Medi-Medi Rule	Claims with the following procedure codes and modifiers were incorrectly denied. H2015:HE:HQ:59 -- H2015:HE:HQ:76 -- H2015:HE:HQ:77 H2015:HE:SC:59 -- H2015:HE:SC:76 -- H2015:HE:SC:77 H2010:HE:HQ:59 -- H2010:HE:HQ:76 -- H2010:HE:HQ:77 H2010:HE:SC:59 -- H2010:HE:SC:76 -- H2010:HE:SC:77
2/9/2011	286	Correction to 1/25/2011 System Update	Due to a system logic issue with update 231, certain DMH claims were incorrectly denied with the error CO-22-N192 (Medicare must be billed prior to the claim submission). This is the correction to the issue.
1/25/2011	231	Taxonomy Codes for Medi-Medi Claims	Allow H2015 and H2010 as directly billable services to Medi-Cal when the provider taxonomy code prefix is no: (103, 104, 207, 208, 363, 364). • H2010 and H2015 services processed prior to April 1, 2011, will not be denied if the rendering provider taxonomy code is blank as long as the Provider Accept Assignment Code (Loop 2300 CLM07) is set to 'C. • H2010 and H2015 services processed on or after April 1, 2011, will be denied if the rendering provider taxonomy code is blank, regardless of the Provider Accept Assignment Code. • It is acceptable to provide the taxonomy code on any claim regardless of the circumstances.
1/25/2011	272	Reactivate Aid Code 4G	Reactivate Aid Code 4G
1/10/2011	43	Information on Void 835's	When reporting a voided original on the 835, units is negative, CLP08 is equal to CLM05-01 of the voiding claim and AMT*B6 is positive. The file name in NM1*74 (Corrected Patient) NM109 is the file name that contained the voiding claim.
1/10/2011	73	Return 835 for approved $0 claims	When a claim results in a $0 total approved amount, it will be reported immediately upon adjudication in the 835.

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1/10/2011	190	Unit of Svc in Reversal Claims	Units of service (SVC05) in reversal claims will be displayed as negative in the 835, as specified in Companion Guide.
1/10/2011	239	SMA Rate Update - Admin Day	Inpatient Admin Day Rate updated
1/10/2011	255	DRC 3 Expires 6/30/2011 Allow H2010 with DRC 3	DRC 3 expires 6/30/2011. Allow DRC 3 to be used with H2010.
1/10/2011	257	New Aid Code 4T	Add 4T for Foster Care. Removed 4G, 5X, 5Y, 0R, 0T, 53, 8Y, 81.
1/10/2011	258	Care Plan Develop and Document G8437 Code for Medi-Medi Claims	Any claim that has procedure code G8437, Care Plan Develop and Document, will not require submission to Medicare before being submitted to SDMC for payment.
12/28/2010	247	Allow H2015 with DRC 3	Allow DRC 3 to be used with H2015.
12/28/2010	240	ARRA FMAP Percentage through 6/30/11	10/01/08 - 12/31/10 = 61.59% 01/01/11 - 03/31/11 = 58.77% 04/01/11 - 06/30/11 = 56.88% 07/01/11 = 50.00%
12/15/2010	76	GT Modifier for Tele-Psychiatry	Allow procedure modifier on tele-psychiatry claims for Medication Support (H2010), Crisis Intervention (H2011), Mental Health Services (H2015), Rehabilitation Services (H2017), and Targeted Case Management (T1017).
12/15/2010	50	SR File now in HTML	Status Report File from ITWS now available in HTML (instead of xml)
12/15/2010	238	Allow H2017 with DRC 3 Add H0032 (Plan Development) for Medi-Medi non-Medicare Services	H2017 (Rehabilitation Services) has been added to the list of procedure codes that can be used with Delay Reason Code 3. Medi-Medi Claims with H0032 (Plan Development) can now be submitted. They are exempt from needing coordination of benefits for Medicare, and can also be used with Delay Reason Code 3.
11/24/2010	235	EPSDT Flag = N	The EPSDT status flag has been set correctly to "N" for the following aid codes: E1, C3, C4, C5, C6, C7, C8, C9, D1, D4, D5, D6, D7. Refer to DMH Aid Codes Master Chart.
11/24/2010	236	Enable Aid Codes 4H and 4L	Emergency Aid Codes effective 1/1/2011.
11/12/2010	138	OHC = “F”	When OHC = "F", the beneficiary will not be treated as a Medicare beneficiary from the OHC perspective.
11/12/2010	140	T1017 and DRC 3	Targeted Case Management (T1017) has been added to the list of procedure codes that can be used with Delay Reason Code 3, until April 30, 2011.
11/12/2010	141	Add Procedure Modifiers for H2015 and H2010 Medi-Medi Claims	Medi-Medi Claims using the following code and procedure modifiers are exempt from needing coordination of benefits for Medicare: H2015 with procedure modifiers of HE:SC for mental health services provided over the telephone. H2015 with procedure modifiers of HE:HQ, and a place of service 99 (Other), for mental health services in the community. If the place of service is not 99, the coordination of benefits for Medicare is required. H2010 with procedure modifiers of HE:SC for medication support services provided over the telephone. H2010 with procedure modifiers of HE:HQ, and a place of service 99 (Other), for medication support services in the community. If the place of service is not 99, the coordination of benefits for Medicare is required.
11/12/2010	144	Provider Lookup Edit	System will attempt to validate the Rendering Provider by using the NPI and Taxonomy code provided at the claim level (if any). If not provided at the claim level, or the information is provided but the lookup fails, system will use the Rendering Provided info at the Billing/Pay-To Level (if any).
10/25/2010	60	Exclude Day of Discharge	Allow outpatient billing on day of discharge from inpatient psychiatric hospital.
10/11/2010	195	Medi-Medi non-Medicare Services (Place of Service 3 or 15)	Any claim that has a Place of Service code of 3 (School) or 15 (Mobile Unit) will not require submission to Medicare before being submitted to SDMC for payment.
10/11/2010	196	Medi-Medi non-Medicare Services (H2017, Rehabilitation Services)	Any claim that has procedure code H2017 (Rehabilitation Services) will not require submission to Medicare before being submitted to SDMC for payment.
10/11/2010	197	Medi-Medi non-Medicare Services (MFT Taxonomy Code)	Any claim that uses the taxonomy code of 106H0000X (Marriage and Family Therapist), with the procedure code H2015, will not require Medicare coordination of benefits.
10/11/2010	198	EPSDT Flag = N on 21st Birthday	The EPSDT eligibility status flag has been set correctly to "N" on the day of the recipient's 21st birthday. Recipients are not eligible for EPSDT on their 21st birthday.

Effective Date	SD2 Prod ID	Title	Technical Description
8/4/2010	157	Remove all timeliness edits from DRC 9 - Sunset date changed to 10/1/2010	This change allows counties to submit SD1 claims that were denied or suspended claims for correction as original or replacement claims in SD2. Counties must indicate claims are SD1 resubmissions with Delay Reason Code 9 (DRC 9) and must submit all SD1 claims no later than October 1, 2010. In relation to SD2 production ID 103, this change removed the timeliness edit after 12 months and extended the end date from receiving claims from August 1, 2010 to October 1, 2010.
7/30/2010	168	FFP Rates for 2010-11	Annual SD2 FFP rates update. Applied rates are based on date of service and claims will not adjudicate without rate availability.
7/2/2010	103	DRC 9 extended to 8/1/2010 (originally 90 days after wave go-live date)	This change allows counties to submit SD1 claims that were denied or suspended claims for correction as original or replacement claims in SD2. Counties must indicate claims are SD1 resubmissions with Delay Reason Code 9 (DRC 9) and must submit all SD1 claims no later than August 1, 2010. (Superseded by SD2 production ID 157).
7/2/2010	143	Aid Code 7K using wrong FFP percentage	Per the DMH Aid Codes Master Chart dated February 11, 2010, aid code '7K' has a restricted scope and no EPSDT SGF. SD2 was updated so that aid code 7K reflects restricted instead of full scope status.
7/2/2010	108	Outpatient Services Lockout on Day of Admission	Claims were denied when clients are seen at Crisis Stabilization Unit (Provider 2441 Mode 10 Service Function 25 HCPC S9484) or Crisis Intervention (Provider 2441 Mode 15 Service Function 70 HCPC H2011) then admitted to Psychiatric Health Facility (Provider 2415 Mode 05 Service Function 20 HCPC H2013). These types of services are allowable on the same day, and SD2 was updated to allow outpatient services on the day of admission.
7/2/2010	37	Vision and Dental OHC	Claims for clients with only Vision and/or Dental OHC should not be denied when these plans have not been billed prior to SD2.
6/15/2010	102	Claims submitted in month 6 but adjudicated in month 7 being denied as late	Component changed: SDMCP2.Components.Adjudication.dll. Business Rules affected by change: DMH Late Submission, ADP Late Submission, DMH Replacement of Claim denied for Late Submission
6/2/2010	133	Santa Barbara Production Issue	Update script to change affected county codes from C42000... to 42
5/18/2010	117	Admin Day Rate Update	Admin Day Rate Updated
5/18/2010	115	Missing Aid Code 8E and 68	Valid codes for DMH and is missing from the reference table. Therefore, valid claims are being denied incorrectly.
5/18/2010	85	Medi-Medi non-Medicare Services	The following HCPCS codes do not require submission to Medicare before being submitted to SDMC for payment: H2011, H2013, H0018, H0019, S9484, H2012, H2019
5/13/2010	52	H2012 Payment Calculation Rules	Daily Rate is not being applied on DMH Services for Quantity more than 4 Units, instead it is applying (Max Allowed Unit Rate * Quantity) rule and it is populating the same in 835 file for Supplemental Amount (AMT*B6) information. The supplemental amount max allowed amount is reported incorrectly for day treatment services only.
5/13/2010	40	Replacement Claim not correctly using the original submission date	Regardless of the number of replacements, the original date of submission that is used in adjudication must be the date of submission of the very first claim in the string of replacements.
5/13/2010	36	DMH 835 Revenue Code SVC04	The 835 returned for inpatient claims does not have SVC04 populated with the revenue code. According to the 835 IG: SVC04 is required when an NUBC revenue code was considered during adjudication in addition to a procedure code already identified in SVC01
3/5/2010	53	H2013 rate is incorrect in DMH Rate Table	Correct rate is $585.30. Table has $603.